STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E076	A. BUILDING _____ B. WING _____	11/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SNYDER NURSING HOME	11 NORTH BROAD ST SALEM, VA 24153

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 11/12/15 through 11/13/15. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 45 certified bed facility was 43 at the time of the survey. The survey sample consisted of 10 current Resident reviews (Resident #1 through Resident #10) and 1 closed record reviews (Resident #11).	F 000	Snyder Nursing Home maintains, in accordance with accepted professional standards and practices, that the resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. Furthermore, Snyder Nursing Home maintains that the resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.	
F 151 SS=D	483.10(a)(1)&(2) RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and clinical record review it was determined the facility staff failed to facilitate voting privileges for 2 of 11 residents (Residents #8 and #9.) Findings: 1. Resident #8 was admitted to the facility on 12/14/14. Diagnoses included hypertension, peripheral vascular disease, depression and anxiety. The clinical record was reviewed 11/13/15 at 10:00 AM.	F 151	On November 16, 2015 a facility Incident Report was filed on behalf of Resident #8 and #9 seeking and providing clarification/information to the Power of Attorneys for Resident #8 and #9 pertaining to each Residents Voter Status and the manner of the vote. On November 20, 2015, The Director of Activities/Social Worker conducted an audit of all current Resident Clinical Records for the presence of an Activity Evaluation and the determination of Voting Interests. Any omissions identified by the Director of Activities/Social Worker were given to the facility Administrator for review and compliance.	11/16/15 11/20/15

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Keith A. D	Administrator	11/23/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 151	Continued From page 1 The latest MDS (minimum data set) dated 8/25/15 coded the resident with intact cognitive skills. The resident required the assistance of one nursing staff member to achieve the ADLs (activities of daily living.) On 12/18/14 the resident was evaluated as to her choice of activities while living at the facility. Clinical documentation indicated the resident was a registered voter and was interested in voting. The manner of the vote (absentee of going to the polls) was not designated in the record. On 11/12/15 at 1:30 PM the resident council group was interviewed. Resident #8 told the surveyor she had not been able to vote in the recent election because the facility ACT/SW (activities/social worker) had not registered her in time. On 11/12/15 at 2:15 PM the ACT/SW was interviewed. She acknowledged the resident had expressed a desire to vote, but she was not registered locally to do so. The ACT/SW said she didn't realize she was not registered to vote locally until it was too late to sign her up. The administrator and DON were informed on 11/12/15 at 4:00 PM. 2. Resident #9 was admitted to the facility on 1/06/15. Diagnoses included coronary artery disease, depression and anxiety. The clinical record was reviewed 11/13/15 at 10:30 AM. The latest MDS (minimum data set) dated 10/13/15 coded the resident with intact cognitive skills. The resident required the assistance of one	F 151	On November 20, 2015, the facility Administrator met with the Director of Activities/Social Worker to review and evaluate the Voting Interests of all residents. It was determined that the process of evaluating Resident Voting Interests will be an on going QA/QI measure for the Director Activities/Social Worker and her staff. To ensure the facilitation of resident voting privileges and to prevent the reoccurrence of this type of deficiency, the Director of Activities/Social Worker or Designee will perform a monthly Activity Evaluation Audit (Briggs form CFS 4-1HF-10) on residents for three months and then randomly for two months. At a minimum, 25% of all Activity Evaluations will be audited. This audit will include a review of Resident Rights with regards to the Resident's Voting Interests., including Voter Status, Voter Interest and cognitive skills and the manner of the vote (absentee or going to polls) Any records not in compliance will be identified (with incident report) and notification to the Administrator for corrective action.	11/20/15 ongoing activity

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F 151	Continued From page 2 nursing staff member to achieve the ADLs (activities of daily living.) On 1/6/15 the resident was evaluated as to her choice of activities while living at the facility. Clinical documentation indicated the resident was a registered voter and was interested in voting. The manner of the vote (absentee of going to the polls) was not designated in the record. On 11/12/15 at 1:30 PM the resident council group was interviewed. Resident #9 told the surveyor she had not been able to vote in the recent election because the facility ACT/SW (activities/social worker) had not registered her in time. The resident stated, "I have always voted. This is the first time in my life I haven't been able to do that." On 11/12/15 at 2:15 PM the ACT/SW was interviewed. She said the resident had expressed a desire to vote, but she was not registered locally to do so. The ACT/SW said she didn't realize she was not registered to vote locally until it was too late to sign her up. "That is something we need to work on.) The administrator and DON were informed on 11/12/15 at 4:00 PM.	F 151	To prevent the reoccurrence of this type of deficiency, Facility policy and procedure pertaining to Resident Voting Rights were reviewed by the Director of Activities/Social Worker and Administrator. This review was completed on November 20, 2015. To prevent the reoccurrence of this type of deficiency, all Activities/Social Services Staff will receive additional training and education pertaining to Resident Rights and the importance of Resident voting rights. This training will be conducted by the Administrator and Silver Chair Learning. This training will be completed by November 30, 2015. To prevent the reoccurrence of this type of deficiency, the Facility Quality Assurance/Quality Improvement Team will review the results of the monthly Activity Evaluation Audit. This will be an ongoing QA/QI measure. To prevent the reoccurrence of this type of deficiency monthly Resident Council meetings will address Resident Rights and include a review of Resident voting needs. This will be an ongoing QA/QI measure.	11/20/15 11/30/15 ongoing activity on going activity
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		

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F 309	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to follow physician orders for 1 of 12 residents (Resident #5). The findings include: The facility staff failed to follow physician orders for administration of medication for Resident #5. Resident #5 was admitted to the facility on 5/8/14 with diagnoses of atrial fibrillation (a-fib), hypertension, depression, Alzheimer's disease, osteoporosis, adult failure to thrive, bipolar disease, and hypothyroidism. The current quarterly Minimum Data Set (MDS) with a reference date of 9/8/15 assessed the resident with long and short term memory deficit and requiring extensive assistance for decision making. The resident was assessed requiring total assistance of 1-2 persons for bed mobility, transfers, dressing, eating, toileting, hygiene, and bathing. The clinical record was reviewed. The record contained the physician recertification orders signed 10/30/15. The orders included an order for "Lanoxin 0.125mg take 1 tablet once daily for a-fib". The medication administration record (MAR) for October 2015 was reviewed. A staff nurse documented the Lanoxin was held on 10/8/15 for a pulse of 58. There was no documentation on the MAR the physician was notified and there was	F 309	Snyder Nursing Home maintains that it does provide and the residents do receive the care and services necessary to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with their individual comprehensive assessment and plan of care. A Facility incident report was filed for resident # 5 on November 13, 2015 reflecting the Nurse's failure to notify the Attending Physician on 10/8/15 of holding "Lanoxin .125mg po daily". The Attending Physician and the POA for resident #5 were notified of this incident on November 13, 2015. Resident #5 was seen by the Physician on the afternoon of November 20, 2015. Facility policy and procedure pertaining to the administration of medications was reviewed by the Medical Director, Director of Nursing and the Facility Administrator on November 19, 2015. The Nurse responsible for notifying the Physician and administering medications for Residents #5 has received additional education, training and counseling with regards to following facility policy and procedure pertaining to the administration of medications. This was conducted by the Director of Nursing on November 20, 2015. Additional training and education will be provided to all Licensed Nurses. This will be completed by the Director of Nursing or her designee by December 13, 2015.	11/13/15 11/20/15 11/19/15 11/20/15 12/13/15

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F 309	Continued From page 4 no order to hold the Lanoxin for a pulse less than 60. The comprehensive care plan was reviewed the careplan contained a problem listed for potential of decreased cardiac output related to a-fib. One of the interventions included to give medications as ordered. The director of nursing was informed of the finding on 11/12/15 at 12:40 p.m. She reviewed the record and stated there was no order to hold the Lanoxin. The administrator and director of nursing were informed of the finding during a meeting with the survey team at 4:00 p.m. on 11/12/15.	F 309	The Clinical records of all other residents were audited on November 20, 2015 to determine if any other medications were held without Physician notification. It was determined that there were no other incidents. The Director of Nursing or her designee will perform a monthly Medication Administration Audit for two months and then randomly for two months consisting of 25% of all facility clinical records. Any records not in compliance will be identified and staff responsible will be counseled in accordance to facility policy. These audits will begin December 1, 2015. The Facility's Pharmacist Nurse Consultant monthly audit will include a review of medication administration records of all residents. Any findings or recommendations will be forwarded to the Director of Nursing. The Facility Quality Assurance and Quality Improvement Team will review the results of monthly medication administration audits and pharmacist audits. This will be an on going quarterly QA/QI activity.	11/20/15 12/1/15 on going activity on going activity
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441		

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F 441	Continued From page 5	F 441		

determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, and clinical record review, the facility staff failed to follow infection control guidelines/practice during a wound care observation for 1 of 11 residents (Resident #4).

The findings include:

The facility staff failed to follow infection control practices during wound care for 1 of 11 residents (Resident #4).

Resident #4 was admitted to the facility 4/03/07 with diagnoses that included but not limited to dementia, anxiety, depression, esophageal reflux disorder, asthma, pressure ulcer, and diabetes.

A review of Resident #4's clinical record revealed on the most recent minimum data set (MDS) with

A facility incident report was completed for Resident #4 on November 13, 2015, reflecting the nurses' failure to follow infection control practices during wound care on November 12, 2015. The attending Physician and Power of Attorney for Resident #4 were notified as of this date. 11/13/15 KAD EMAIL HHE

Resident #4 identified in this sample has been assessed to determine if there has been any change in condition resulting from observations made on November 12, 2015. No negative patient outcomes where identified. Resident #4 was seen by the attending Physician on November 18, 2015. 11/18/15

On November 13, 2015, the Facility Nurse observed not using acceptable infection control practice did receive counseling from the Director of Nursing. This counseling session included a review of facility policy and procedure pertaining to infection control guidelines while performing wound care. This Nurse also received additional training on infection control practices pertaining to wound care, as well as, pressure ulcer assessment, intervention and prevention. This Nurse will complete all training exercises by November 30, 2015. 11/30/15

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F 441	Continued From page 6	F 441		

an assessment reference date of 9/15/15, the facility staff assessed the resident to usually understand and to be understood. She was assessed to have a cognitive summary score of 10.

A wound care observation was conducted on 11/12/15 at 3:05 pm, for Resident #4. The nurse performing the wound care (RN#1) was observed to not follow infection control practices during the wound care. RN#1 was observed cleaning the two open stage II wounds on the resident's left buttock she cleaned the wounds with a gauze and hibiclens she cleaned one wound with the gauze then went to the second wound. She then went to the Right buttock and cleaned all three stage two wounds with one gauze and Hibiclens. RN#1 changed her gloves and washed her hands, then applied the santyl ointment to the open wounds on both buttocks using one Q-tip on the left and another Q-tip on the right buttock. RN# 1 failed to change her gloves or wash her hands between treatments of the separate wounds. She failed to use separate gauze for each wound and a separate Q-tip for each wound.

After the wound care was complete the nurse was asked why she didn ' t change gauze to clean each wound site and use separate Q-tips with the application of the santyl ointment. RN #2 stated " I see what you mean. "

The administrator, and director of nursing, was informed of the findings during a meeting with the survey team on 11/12/15 at 4:00 p.m.

Prior to exit no further information was provided to the surveyor related to the wound care.

By November 30, 2015, all facility licensed nurses will have completed additional training/education in the areas of infection control practices during wound care, infection control basics and pressure ulcer assessment, interventions and prevention. 11/30/15

The Facility policy pertaining to infection control will be reviewed by the Medical Director, Director of Nursing and Administrator. If indicated, revisions will be made to reflect current guidelines. This review will be completed by November 30, 2015. 11/30/15

All Facility staff will receive additional training and education pertaining to appropriate hand washing techniques to prevent the spread of infection. This will be completed by November 30, 2015. 11/30/15

The Director of Nursing or designee will perform random infection control compliance checks. The results of these random checks will be forwarded to the Administrator for review. This will be an ongoing QA/QI measure. ongoing activity

The Facility Quality Assurance/Quality Improvement Team will review compliance with infection control guidelines quarterly. ongoing activity

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F 504 SS=D	Continued From page 7 483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN The facility must provide or obtain laboratory services only when ordered by the attending physician. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to obtain a physicians order prior to obtaining the laboratory test for 1 of 11 residents, Residents #4. The finding included: 1. For Resident #4 the facility staff failed to obtain physicians orders for laboratory test; a comprehensive metabolic panel (CMP). Resident #4 was admitted to the facility 4/03/07 with diagnoses that included but not limited to dementia, anxiety, depression, esophageal reflux disorder, asthma, pressure ulcer, and diabetes. A review of Resident #4's clinical record revealed on the most recent minimum data set (MDS) with an assessment reference date of 9/15/15, the facility staff assessed the resident to usually understand and to be understood. She was assessed to have a cognitive summary score of 10. Resident #1's clinical record was reviewed 11/12/15 and revealed the results of a CMP done on 9/24/15. However, the surveyor could not locate a corresponding order. On 11/15/15 at 2:15pm the director of nurses was asked to assist in locating the orders for the labs.	F 504 F 504	Snyder Nursing Home maintains, in accordance with accepted professional standards and practices, that Lab Services are only conducted when ordered by the Physician. On November 13, 2015, a Facility Incident Report was filed on behalf of Resident #4 reflecting that a lab study (CMP) was performed on 9/24/15 without a Physician order. The attending Physician and Power of Attorney for Resident #4 were notified as of November 13, 2015. Resident #4 identified in this sample has been assessed to determine if there has been a change in condition resulting from the non-physician order lab study of 9/24/15. Resident #4 was seen by the attending Physician on November 18, 2015. On November 20, 2015, the clinical records of all other Residents were audited to determine if all lab studies were completed as ordered by the Physician. This audit was conducted by the Director of Nursing and the Director of Medical Records. It was determined that there were there were no other omissions/errors pertaining to Physician ordered lab studies. To prevent the reoccurrence of this type of deficiency, facility policy and procedure pertaining to Physician ordered routine lab Studies will be reviewed by the Director of Nursing, Medical Director and Administrator. This review will be completed by November 30, 2015.	11/13/15 11/13/15 11/18/15 11/20/15 11/30/15

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F 504	Continued From page 8 On 11/12/15 at 3:15pm, the director of nurses informed the survey team she did not have a current order. Prior to exit no further information was provided related to the lab test CMP without an order.	F 504	To prevent the reoccurrence of this type of deficiency, the Director of Nursing or Designee will perform a monthly Lab Study Compliance Audit for three months and then randomly for two months. At a minimum, 25% of all resident records will be audited. This audit will include a review of Physician orders for routine lab studies, as well as, verification that the monthly physician order sheets (produced by the pharmacy) reflect correct lab orders. Any non compliance will be identified and the responsible staff will be counseled in accordance with established facility policy. These audits will begin December 1, 2015 To prevent the reoccurrence of this type of deficiency, the Facility Pharmacist's monthly audit will include a review of Lab Studies as ordered by the Physician. Any findings or recommendations will be forwarded to the Director of Nursing. This will be an ongoing QA/QI measure. To prevent the reoccurrence of this type of deficiency, all licensed Nursing Staff will receive additional training and education pertaining to orders for Routine Lab Studies and Medical Records Documentation. This training will be conducted by the Director of Nursing and Silver Chair Learning. This training will be completed by December 13, 2015. To prevent the reoccurrence of this type of deficiency, the Facility QA/QI Team will review the results of the monthly Nursing lab audits and the monthly Pharmacist Nurse Consultant audits. This will be an ongoing QA/QI measure.	12/1/15 ongoing activity 12/13/15 ongoing activity